

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6529, Fax 761-6249, email clutea@co.warren.ny.us

Volunteer Fire / Ambulance Worker Accident Report

*This form is to be completed by the injured worker.
Answer all questions fully, attach additional sheets as needed.*

Name: _____ SSN: _____

Address: _____

Phone: _____ Date of Accident: _____ Approximate Time: _____

Fire Dept or Ambulance Squad Name: _____

Location of Accident (Address): _____

What part of your body did you hurt? _____

Describe what you were doing before you were hurt and describe in detail how the accident happened: _____

Witnesses: _____

Did you see a doctor? _____ Yes _____ No If yes, provide:
Physician Name: _____ Hospital Name: _____

Were you told to see that doctor or another doctor again? _____ Yes _____ No If yes, provide:
Physician Name: _____ Date of next office visit: _____

Have you previously injured or had trouble with this part of your body before? _____ Yes _____ No
If yes, provide: When _____ Describe prior injury or illness? _____

*It is a crime punishable as a Class A Misdemeanor under the laws of the State of New York for a person in and by a written instrument to knowingly make a false statement or to make a statement which such person does not believe to be true.
By signing below you independently and voluntarily request that your name NOT be entered on the "Log of Work-Related Injuries and Illness," in case of work-related illness or injury.*

Today's Date

Injured Worker Signature

Department/Squad Supervisor Signature

Note to Supervisors: Immediately send this form along with the VF-2 or VAW-2 form to Self-Insurance.
If you have any questions or concerns regarding how this accident occurred, or if you want to provide more information, please call Self-Insurance at 761-6529.